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SENATE BILL 3127 By
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HOUSE BILL 2949
By McDaniel

AN ACT to amend Tennessee Code Annotated, Title 56, to enact
the Consumer Health Care Advocacy Act.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF TENNESSEE:

SECTION 1. This act shall be known as and may be cited as the "Consumer Health
Care Advocacy Act".

SECTION 2. As used in this act "health insurance issuer" means an entity regulated
under this title that offers health insurance coverage, which shall include any individual,
franchise, blanket or group health insurance policy, medical service plan contract, hospital
service corporation contract, hospital and medical service corporation contract, fraternal benefit
society contract, or such contract with a health maintenance organization or managed care
organization.

POINT OF SERVICE

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding
the following as a new section to be appropriately designated:

Section ____.

(a)(1) If a health insurance issuer offers to enrollees health insurance
coverage through a health maintenance organization, such health insurance
issuer shall offer to its enrollees (at the time of enrollment and at least once each
year) either:

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(A) a point of service option through the health maintenance organization which provides benefits for covered services through health professionals and providers who are not members of such a network; or

(B) a preferred provider organization plan.

(2) Before an enrollee consents to the insurance contract, the health insurance issuer shall fully disclose to the enrollee the terms and conditions of each option, and the costs associated with each such option provided by the issuer.

(b) The amount of any additional premium required for the options described in subsection (a) may not exceed an amount that is fair and reasonable, as determined by the commissioner of commerce and insurance, based on the nature of the additional coverage provided. In addition, any additional amount for premiums, copayments or other forms of cost-sharing may not exceed twenty percent (20%) of the plan's normal charges to enrollees for such costs. Provided that the deductible shall not increase for the point of service option and any copayment shall not exceed thirty dollars (\$30.00).

(c) Under the option described in subsection (a), the health insurance coverage shall provide for reimbursement rates for covered services offered by health professionals and providers who are not participating health professionals or providers that are not less than the reimbursement rates for covered services offered by participating health professionals and providers. By agreeing to accept the enrollee the nonparticipating professional or provider agrees to accept only the reimbursement offered by the plan, including any applicable, additional copayments or cost-sharing. When reimbursing for services of a nonparticipating professional or provider, the health insurance issuer may make direct payment to the insured.

NETWORK ADEQUACY

SECTION 4. Tennessee Code Annotated, Section 56-32-204(e), is amended by adding the following language after the first sentence:

The applicant shall meet the network adequacy requirements established pursuant to Section 5 of this act.

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 32, Part 2, is amended by adding the following language as a new, appropriately designated section:

Section _____. (a) Each health maintenance organization shall maintain a network that is sufficient in numbers and types of providers to assure that all covered benefits to covered persons will be accessible without unreasonable delay. In the case of emergency services, covered persons shall have access to health care services twenty-four (24) hours per day, seven (7) days per week. Sufficiency shall be determined in accordance with the requirements of this section and may be established by reference to any reasonable criteria used by the health maintenance organization, including but not limited to:

- (1) Provider-covered person ratios by specialty;
- (2) Primary care provider-covered person ratios;
- (3) Geographic accessibility;
- (4) Waiting times for appointments with participating providers;
- (5) Hours of operation; and
- (6) The volume of technological and specialty services available to serve the needs of covered persons requiring covered technologically advanced or specialty care.

The network adequacy standards description shall be available to the commissioner upon request.

(b) In addition to establishing the standards required pursuant to subsection (a), the health maintenance organization's network, shall demonstrate the following:

(1) An adequate number of accessible acute care hospital services, within a reasonable distance or travel time, or both;

(2) An adequate number of accessible primary care providers, within a reasonable distance or travel time, or both; the standard for this subdivision shall be not more than thirty (30) miles or thirty (30) minutes;

(3) An adequate number of accessible specialists and sub-specialists, within a reasonable distance or travel time, or both; the standard for this subdivision shall be:

(A) For counties that are included within a metropolitan statistical area, as defined by the federal Office of Management and Budget; having a population of five hundred thousand (500,000) or more, the standard shall be not more than twenty (20) miles or twenty (20) minutes, so long as specialists or sub-specialists within such area are available and agree to the terms and conditions of the contract or plan; and

(B) For counties that are included within a metropolitan statistical area, as defined by the federal Office of Management and Budget; having a population of five hundred thousand (500,000) or less, the standard shall be not more than thirty (30) miles or thirty (30) minutes;

(4) The procedures for making referrals within and outside its network that, at a minimum, must include the following:

(A) A comprehensive listing, made available to covered persons and health care providers, of the plan's network participating providers and facilities;

(B) A provision that referral options cannot be restricted to less than all providers in the network that are qualified to provide covered specialty services;

(C) Timely referrals for access to specialty care;

(D) A process for expediting the referral process when indicated by a medical condition;

(E) A provision that referrals approved by the plan cannot be retrospectively denied except for fraud or abuse;

(5) The process for monitoring and assuring on an ongoing basis the sufficiency of the network to meet the health care needs of populations that enroll in plans;

(6) The quality assurance standards, adequate to identify, evaluate, and remedy problems relating to access, continuity, and quality of care;

(7) The efforts to address the needs of covered persons with limited English proficiency and illiteracy, with diverse cultural and ethnic backgrounds, and with physical and mental disabilities;

(8) The system for ensuring the coordination and continuity of care for covered persons referred to specialty providers;

(9) Any other information required by the commissioner to determine compliance with the provisions of this part.

(c) In any case where the health maintenance organization has no participating providers to provide a covered benefit, the health maintenance organization shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers.

(d) The health maintenance organization shall only market a network plan in a geographic area where network providers are accessible without unreasonable delay.

(e) In determining whether a health maintenance organization has complied with this section, consideration shall be given to the relative availability of health care providers, specialists and subspecialists in the service area under consideration. Relative availability includes the acceptance by the health care provider, specialist or subspecialist of the terms, conditions and fees offered under the contract or plan.

(f) No managed care plan shall deny or restrict in-network covered benefits to a covered person solely because the covered person obtained treatment outside the network. This protection shall be disclosed in writing to the covered person. Nothing in this subsection shall be construed to require a managed care plan to pay for any benefit obtained outside the plan's network unless the contract or certificate provides for that out-of-network benefit.

SCOPE OF SERVICES

SECTION 6. Tennessee Code Annotated, Title 56, is amended by adding the following as a new chapter to be appropriately designated:

Section _____. In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health insurance issuer may not engage in any practice that has the effect of contractually discriminating against a provider:

(1) based on the race, national origin, sex, language, age, or disability of the provider; or

(2) based on the socio-economic status, disability, health status, or anticipated need for health services of a patient of the provider.

Except in the case of intentional discrimination, it shall not be a violation of this section for any person to take any action otherwise prohibited under this subsection, if the action is required by business necessity.

Section _____. In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health insurance issuer may not engage in any practice that has the effect of contractually discriminating against a provider concerning reimbursement for any service which is within the lawful scope of practice of that provider if the service is a covered benefit under the plan.

Section _____. (a) In selecting among providers of health services for membership in a provider network, or in establishing the terms and conditions of such membership, a health insurance issuer may not discriminate against a class of providers who provide services that are covered by the plan by:

(1) prohibiting a class of providers from membership in the provider network who provide covered services that are within the providers' scope of practice; or

(2) selecting an inadequate number of providers in the community where such plan operates to meet the service needs and preferences of enrollees for a certain class of health care providers for covered services.

For purposes of this act the term "community where such plan operates" means the community service agency area, as defined by Title 37, Chapter 5, Part 3.

(b) Every year each plan shall survey its enrollees to determine enrollee preferences for the class of providers who provide services covered by the plan which are within the scope of practice of more than one class of providers in order to determine the need for adequate numbers of those classes of health care providers to be included within the network.

(c) As used in this section “class of health care providers” means all health care providers licensed and certified by the state licensing boards within each profession of the healing arts category established under Tennessee Code Annotated, Title 63.

DIRECT ACCESS

SECTION 7. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as a new, appropriately designated section:

Section ____.

(a) A health insurance issuer shall, for women enrollees or subscribers, designate ob/gyns as primary care providers.

(b) If a plan or contract of a health insurance issuer provides for an annual visit to a specialist or subspecialist, including but not limited to an annual dental or eye examination or visit to an ob/gyn, the plan or contract shall not require the enrollee or subscriber to first obtain a referral from a primary care physician to the specialist or subspecialist for such visit.

(c)(1) Each health insurance issuer shall develop and maintain written policies and procedures to designate specialists or subspecialists, as approved by the medical director of such plan, as primary care providers of enrollees or subscribers with life threatening, chronic, disabling or degenerative conditions or diseases which require ongoing specialty care. The policies and procedures shall provide an appeals process for any denials of such specialists or subspecialists as primary care providers.

(2) The commissioner of health shall, by rule, designate those categories of specialists or subspecialists which must be designated as primary care providers for those meeting the requirements of subdivision (1).

STANDING REFERRALS

SECTION 8. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as a new, appropriately designated section:

Section _____. Each health insurance issuer shall develop and maintain written policies and procedures for the provision of standing referrals to subscribers or enrollees with chronic and disabling conditions which require ongoing specialty care. The standing referral shall be for a period not to exceed twelve (12) months. Under such procedures, the primary care physician shall not be required to see the subscriber or enrollee following the initial referral to the specialist at least until the beginning of the plan year following such referral.

CONTINUITY OF CARE

SECTION 9. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as a new, appropriately designated section:

Section ____.

(a) Each health insurance issuer shall allow a subscriber or enrollee:

(1) to continue receiving care when medically necessary from a treating provider who is terminated without cause for a period of one hundred eighty (180) days from the date of termination, provided the subscriber or enrollee has a life-threatening condition or a disabling and degenerative condition.

(2) who is in the third trimester of pregnancy to continue care with a treating provider who is terminated without cause until completion of postpartum care.

(b) The provisions of subsection (b) shall only apply if the treating provider agrees to continue to be bound by the terms and conditions of the contract for such continued care.

(c) Each health insurance issuer shall provide for continued care for a subscriber or enrollee being treated at an in-patient facility until the patient is discharged.

PHARMACY AND PHARMACY ACCESS

SECTION 10. Tennessee Code Annotated, Title 56, Chapter 7, Part 23, is amended by adding the following language as new, appropriately designated sections:

Section _____. If a health insurance issuer revises its drug formulary to remove drugs from a previously approved formulary, the health insurance issuer shall allow a subscriber or enrollee to continue receiving a drug the subscriber or enrollee had been receiving prior to the change, and to reimburse the provider for such drug, until the subscriber or enrollee completes the appeals process or until an acceptable substitute is found.

Section _____. No health insurance issuer may:

(1) Deny any licensed pharmacy or licensed pharmacist the right to participate as a participating provider in any policy, contract or plan on the same terms and conditions as are offered to any other provider of pharmacy services under the policy, contract or plan;

(2) Prevent any person who is a party to or beneficiary of any policy, contract or plan from selecting a licensed pharmacy of such person's choice to furnish the pharmaceutical services offered under any contract, policy or plan, provided that the pharmacy is a participating provider under the same terms and conditions of the contract, policy or plan as those offered to any other provider of pharmacy services; or

(3) Permit or mandate any difference in coverage for or impose any different conditions, including copayment fees, so long as the provider selected is a participant in the contract, policy or plan involved.

SECTION 11. This act shall take effect July 1, 1998, the public welfare requiring it.